DEPARTMENT OF LABOR
WORKERS' COMPENSATION DIVISION
NATIONAL LIFE DRIVE, DRAWER 20
MONTPELIER, VT 05620-3401
(802) 828-2286

www.labor.vermont.gov

DOL Form 27 Rev 5/05

State File No.: _____
Insurance Co. File No.: _____
Date of Injury: _____
FEIN: _____
Social Sec. Number: _____

EMPLOYER'S NOTICE OF INTENTION TO DISCONTINUE PAYMENTS

The Form 27 and supporting documentation must be received by the claimant and the Department of Labor at least 7 days before the actual discontinuance pursuant to § 643a. ATTACH SUPPORTING EVIDENCE.

Employee Name: _____ Employer: _____

Employee Address: _____

Effective _____ the following benefits will be DISCONTINUED for the reason(s) checked below.

☐ Temporary total disability ☐ Temporary partial disability; or ☐ Medical benefits

To the above name employee for the following reason(s):

☐ 1. Claimant has reached a medical end result. Report of Dr. _____ attached.
"End Medical Result" or "Medical End Result" is defined as "the point at which a person has reached a substantial plateau in the medical recovery process, such that significant further improvement is not expected, regardless of treatment".

☐ 2. Claimant has been released for work with or with restrictions but has not made a reasonable effort to find such work OR has refused an offer of suitable work. Written documentation establishing the following must be attached:
   a. Medical documentation indicating the claimant has been released to return to work with or without restrictions attached;
   AND
   b. Written evidence showing that the claimant has been notified of the fact his/her release and his/her obligation to conduct a good faith search for suitable work OR to accept an offer of suitable work attached; AND
   c. Written explanation as to why you (the adjuster) feel the claimant has failed to make a reasonable effort to find suitable work attached; OR written documentation from the employer that shows they have suitable work but the claimant has refused such employment attached.

☐ 3. Medical treatment is inappropriate or unrelated to work injury. Medical evidence attached.
Specify treatment: _____

☐ 4. No medical documentation supporting ongoing disability and/or treatment. Please attach a copy of your letter to medical provider and any response received, if you received no response please check here ☐.

☐ 5. Claimant has failed to attend a scheduled I.M.E. Carrier's scheduling letter, documentation of non-attendance and reason (if known) attached.

☐ 6. Other (specify with attached evidence): _____

ISSUED BY: REVIEWED BY:

_____ _____
Insurance Carrier Date Notice Mailed

_____ _____
Insurance Adjuster (Print Name) Date Reviewed

_____ _____
Insurance Adjuster Signature Commissioner or Designee Signature

NOTICE TO EMPLOYEE'S OF RIGHT TO APPEAL

IF YOU DISAGREE WITH THE NOTICE TO DISCONTINUE BENEFITS, you may request a hearing IN WRITING to the Department of Labor at the address above. ATTACH medical documentation and any other information to support your appeal. PLEASE BE SURE TO PUT YOUR STATE FILE NUMBER ON YOUR HEARING REQUEST.